

Canadian Health Care: A Focus on Rural Medicine

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Rural medicine has played a significant role within the overarching field of Canadian health care. As an expansive country, Canada encompasses 10 million square kilometres, the majority of which is considered rural and is home to 32% of the population. In 2005, 21% of Canadians lived in communities with populations of less than 10,000, and 9.4% of physicians lived and worked in those same communities.¹ The majority of physicians are focused in dense urban epicentres where technology and resources are more widely available. Since this technology is not always available in rural centers, rural physicians tend to rely more on small groups and a wide range of skills. Interestingly, as one transitions from urban centres to more rural settings, there is a significant change in health outcomes. For example, rural regions are reported to have an increased prevalence of smoking, obesity, circulatory diseases and injuries.² Although the Canada Health Act states that all Canadians should have reasonable access to health care services, the observed differences of health outcomes in rural regions could be attributed to limited access to services and higher expenses for the individual if specialized care is required.^{1,3} Of equal importance is the difficulty in recruiting and retaining physicians in rural regions. Strategies such as providing financial incentives or creating a Rural and Remote Access Fund have not managed to successfully curtail the continuing loss of physicians to urban settings.⁴

In addition to these strategies, medical education programs in Canada have recognized the need for rural physicians, and as a result have initiated a variety of programs to promote rural areas to medical undergraduates.⁵ For example, the distributed sites of the University of British Columbia Medical Program have been designed to expose medical students to rural British Columbia. To this extent, this program has expanded to include a distributed site in the interior of British Columbia for 32 medical students in addition to the northern and island British Columbia sites, which each house 32 medical students. This totals almost 100 medical students training at campuses across the province.⁶ The education provided at these distributed sites allows students to adapt to the lifestyle of a rural environment. Studies have shown that several factors, such as family background, time spent in a rural area, and specific personal values and attributes all contribute to medical students studying, and eventually practicing, in a rural setting.⁷

Numerous additional programs have been proposed and implemented in British Columbia to facilitate the student rural

experience. This includes the integrated clerkship program and the rural family practice clerkship implemented in the medical school curriculum.⁸ These programs provide a well-rounded medical education, as rural physicians have a greater amount of independence, autonomy and responsibility compared to their urban counterparts due to their relative geographical isolation.⁹ It has been shown that family physicians in less populated regions are involved in a wide variety of procedures, such as deliveries, anesthesia, geriatric, and surgical care, while urban general practitioners tend to be limited in the type of procedures they offer.⁹


Volume 2, issue 2 of the *UBCMJ* features contributions from Dr. Stefan Grzybowski and Dr. John Wootton. Dr. Stefan Grzybowski is a family physician researcher and Professor in the University of British Columbia's Department of Family Practice. He is Co-Director of the Centre for Rural Health Research and also the Co-Leader of the Michael Smith Foundation for Health Research's B.C. Rural and Remote Health Research Network. In the featured article titled "Sustaining the Health Care Services of Rural Communities: The Role of the University", Dr. Grzybowski discusses the impact of reduced access to adequate health care in rural communities and the repercussions this has on populations inhabiting these regions. Dr. John Wootton, current president of



the Society of Rural Physicians of Canada (SRPC), describes the role of the SRPC in the support and development of rural physicians in Canada. He also describes his career transition from Toronto urban medicine to northern Ontario (Sioux Lookout) and rural Quebec.

These articles provide the backdrop for a discussion of rural practice in Canada. However, rural medicine exists beyond our borders, warranting a global discussion of rural health care. Therefore, in this current issue, the *UBCMJ* facilitates a global discussion on rural health care, touching on topics including community health care in Botswana, and health care in Cuba (Bana, Page 20; Fulton, Page 23). Also, an academic article outlining the prevalence of anemia in a select population of children in the Indian Himalayas relays an important discussion of rural access and preventive medicine in a global setting (El-Zammer, Page 13).

Delivering high-quality, comprehensive health care to Canadians is a challenge that needs to be addressed. As many Canadians live in rural communities, medical students and physicians should consider a rural practice. Rural physicians achieve strong patient–doctor relationships and maintain a high level of continuity of care, along with providing many services often deferred to hospital specialists in an urban setting. The *UBCMJ* provides a forum for academic dialogue with respect to rural practice. Hopefully this will allow medical students, faculty, and practicing physicians to better appreciate the complexity and increasing dilemma of this topic. On behalf of the *UBCMJ*,

we anticipate that this issue will expose strategies and possible solutions to overcome rural health care discrepancies across Canada. In addition, these strategies may lead to positive change in the education and training of medical students nationally and globally. 

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